DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Supportive Living
DSL-445 (Rev. 11/2000)

STATE OF WISCONSIN
☐ New plan
☐ Plan update
☐ Annual recertification

INDIVIDUAL SERVICE PLAN - MA WAIVERS

Waiver Type ☐ 1. CIP 1A ☐ 2. CIPII ☐ 3. COP-W 4. CIP 1B ☐ 5. BIW ☐ 6. CSLA			Name - Case Manager
Name - Participant	Date - LOC Determination (CIP 1A and B, CSLA only)		Date - Service Plan Development
Address (Street)		Date - Functional Screen	Cost Share Amount $
City, State, Zip	Telephone Number	Level of Care	Waiver Cost / Day / Total $
MA Number	**Planned Community Living Arrangement Type** ☐ CBRF (_____ No. of beds in CBRF) ☐ Adult family home ☐ Other (specify) ☐ Living with family or others in a home / apt. ☐ Living alone ☐ Supervised apartment ☐ Assisted living		

SPC*	Service Type	Name and Address - Service Provider	Date - Start	UnitCost ($ / hr.; day)	Units of Service and Frequency (# / day; week; month)	Daily Cost (yearly / 365)	Funding Source (CIP 1, CSLA, BIW, SSI, COP, CIP II, Cost Share, MA Card, etc.)

*Medicaid care services will not have a SPC number.

Name - Administering County Agency	Telephone Number	Name - Case Manager	Telephone Number
Mailing Address (Street / PO Box)		Address	
Name - Guardian		Telephone Number - Home	Telephone Number - Work
Mailing Address (Street / PO Box)		City	State / Zip
IN CASE OF EMERGENCY, NOTIFY - Name		Telephone Number - Home	Telephone Number - Work
Address		City / State / Zip	Relationship

I have been informed that I have a choice between an ICF-MR or nursing home (dependent on waiver type) and community services through a MA Community Waiver Program.
By my signature below I indicate I have chosen to accept community services through a MA Community Waiver Program.
I have been informed of and understand my choices in the waiver programs, including approval or rejection of the services and providers listed on this service plan.
I have been informed of and understand my rights and responsibilities in the MA Community Waiver Programs.
I was informed verbally and in writing of my rights and responsibilities.

SIGNATURE - Participant	Date Signed	**SIGNATURE -** Guardian / Authorized Representative	Date Signed
SIGNATURE - (identify) Witness	Date Signed	**SIGNATURE -** (identify) Witness	Date Signed
SIGNATURE - Case Manager	Date Signed		

Completion of this form meets the requirements of Federal Regulation 42 CFR 42 CFR 441.

Annual Recertification for CIP 1A, CIP 1B, and CSLA only:

I certify that 1 and 2 have been completed for annual recertification for participation in the CIP 1A, CIP 1B, or CSLA program and are ON FILE in the county agency (check):

1. ☐ The DD Level of Care Form (DSL-879) has been reviewed. Page 3 of the DSL-879 form was signed and dated by a QMRP. (Check appropriate year ☐ 2, ☐ 3, ☐ 4, ☐ 5.) (Note: for year 6, a new DD Level of Care form must be submitted to and rated by BDDS prior to or in the recertification month established by BDDS.)

   Check if applicable: ☐ I wish to change the recertification month. I have adjusted the month of the DD LOC Review Date on Page 3 of the DSL-879 form. Enter the adjusted date here: ____/____/_____. I understand this date can be earlier, but not later than the previous DD LOC Review Date and that this will establish the date for subsequent DD LOC Reviews and deadlines. Counties may choose to move a person's recertification month to an earlier date to balance workloads or for other purposes. The recertification month cannot be moved to a later month due to the requirement that a Level of Care must be reviewed within each 12 month period.

2. ☐ Annual MA Waiver Eligibility and Cost Sharing Worksheet (DSL-919) or CARES screen has been completed.

I have attached and sent a copy of the current ISP (including participant / guardian signature page) along with a copy of this Annual Recertification page to BDDS. This ISP reflects current information about the person and his / her supports, services and costs. BDDS will sent a recertification letter after receipt of this information.

SIGNATURE - Case Manager	Today's Date